DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

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- "Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse", Booklet, ICN 907798, downloadable

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Documentation Requirements for Home Health Prospective Payment System (HH PPS) Face-to-Face Encounter

Provider Types Affected

This MLN Matters® Special Edition Article is intended for physicians who refer patients to home health, order home health services, and/or certify patients' eligibility for the Medicare home health benefit, home health agencies, and non-physician practitioners (NPPs).

What Providers Need to Know

Effective January 1, 2011, the Affordable Care Act mandates that prior to certifying a beneficiary's eligibility for the HH benefit, the certifying physician must document that he or she or an allowed non-physician practitioner (NPP) had a face-to-face encounter with the beneficiary.

Background

The regulation governing the face-to-face encounter requires that as a condition for payment, the encounter occur within 90 days prior to the start of care or up to 30 days after the start of care and the documentation of the encounter includes "*…an explanation of why the clinical findings of such*

encounter support that the patient is homebound and in need of either intermittent skilled nursing services or therapy services…."

Improper Payments by Type of Error

The majority of HH PPS improper payments are due to "insufficient documentation" errors. "Insufficient documentation" errors occur when the medical documentation submitted is inadequate to support payment for the services billed or when a specific documentation element that is required is missing.

Most "insufficient documentation" errors for HH PPS result from claims where the narrative portion of the face-to-face encounter document does not sufficiently describe how the clinical findings from the encounter support the beneficiary's homebound status and the need for skilled services.

Note: The homebound status of the patient and his/her need for skilled services must be written in a brief narrative, signed by the physician, titled "Home Health Face to Face Encounter", and dated.

Some of the records reviewed contained very little clinical information beyond simple lists of diagnoses, recent injuries, or procedures. For example, "insufficient documentation" includes instances where the need for skilled nursing is justified with only a listed diagnosis, such as chronic obstructive pulmonary disease (COPD), osteoarthritis, or fracture of the humerus; and the beneficiary's homebound status is documented only by a notation such as "gait abnormality" or "taxing effort."

As described in the regulation (42 CFR 424.22(a)(1)(v)), such information is not sufficient. The face-to-face encounter documentation must explain why the findings from the encounter support the medical necessity of the services ordered and the beneficiary's homebound status. Also, the "Medicare Benefit Policy Manual" states that the documentation must include a brief narrative that "describes how the patient's clinical condition as seen during that encounter supports the patient's homebound status and need for skilled services."

Required Narrative Requirements

The two elements of the required brief narrative for documenting the Home Health face –to-face encounter are:

1. Confined to the Home – Describe why the patient is homebound. An individual shall be considered "confined to the home" (homebound) if both of the following two criteria are met:
   A. The patient must either:
      - Because of illness or injury, need the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person in order to leave their place of residence, OR
      - Have a condition such that leaving his or her home is medically contraindicated.

Examples:

a. Ambulates limited distance of 125' with assistance of a walker due to acute stroke;

b. Poor endurance, shortness of breath with minimal ambulation due to congestive heart failure (CHF) and needs assistance to leave the home.

B. There must exist:

- A normal inability to leave home; AND
- Leaving home must require a considerable and taxing effort.

Examples:

a. Deteriorating mental status, unable to leave home unsupervised;

b. Frequent seizure activity, requires supervision/assistance of another person

2. Need for Skilled Services- *To qualify for home health services, the beneficiary must need intermittent skilled nursing services, physical therapy (PT), or speech language pathology (SLP) services.* Describe what the RN, PT, or SLP and other services will be doing in the home. For example, "skilled nursing required to assess and manage new COPD regimen."
   - Skilled nursing services must be reasonable and necessary for the treatment of the patient's illness or injury. Skilled nursing services can be, but are not limited to:
     - Teaching/training
     - Observe/assess
     - Complex care plan management
     - Administration of certain medications
     - Tube feedings
     - Wound care, catheters and ostomy care
     - NG and Tracheostomy aspiration/care
     - Psychiatric evaluation and therapy
     - Rehabilitation nursing
   - PT, OT, SLP services must be reasonable and necessary for the treatment of the patient's illness or injury or to the restoration or maintenance of function affected by the patient's illness or injury within the context of his or her unique medical condition. Assuming all other eligibility and coverage requirements have been met, one of the following three conditions must be met for therapy services to be covered :
     a. The skills of a qualified therapist are needed to restore patient function.

- Therapy services must be provided with the expectation that, based on the assessment made by the physician of the patient's restorative potential, the condition of the patient will improve materially in a reasonable and generally predictable period of time.

b. The skills of a qualified therapist are needed to design or establish a maintenance program.

- The clinical condition of the patient requires the specialized skill, knowledge and judgment of a qualified therapist to design or establish a maintenance program, related to the patient's illness or injury, in order to ensure the safety of the patient and the effectiveness of the program.

c. The skills of a qualified therapist (not an assistant) are needed to perform maintenance therapy.

- The clinical condition of the patient is such that the complexity of the therapy services required to maintain function involves the use of complex and sophisticated therapy procedures to be delivered by the therapist himself/herself (and not an assistant) or the clinical condition of the patient is such that the complexity of the therapy services required to maintain function must be delivered by the therapist himself/herself (and not an assistant) in order to ensure the patient's safety and to provide an effective maintenance program.

Example: Ms. Jane Doe is a 99 year old female hospitalized with congestive heart failure (CHF) exacerbation (she has co-morbid asthma and low vision). She is going home and needs skilled nursing due to a new medication regimen and high potential for hospital readmission. She also needs in-home PT for strength training due to deconditioning during CHF exacerbation and safety assessment because she is at risk for falls. She is unable to leave the house without a walker.

Element 1:"Confined to the Home" Status due to deconditioning, CHF, and low vision.
Element 2: Skilled Nursing is required due to medication changes. PT is required for strength training and home assessment due to fall risk.

Additional Information

Attached to this article are documents that you may want to review showing correct and incorrect examples of documentation.

A list of frequently asked questions is available at http://www.cms.gov/Center/Provider-Type/Home-Health- Agency-HHA-Center.html on the CMS website.

MLN Matters® Article SE1038 provides guidance for the original face-to-face implementation, is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1038.pdf on the CMS website.

You may also want to review MLN Matters® Article MM8444 which provides clarification of the definition of "confined to the home" as stated in the revised Section 30.1.1 of Chapter 7 of the "Medicare Benefit Policy Manual". The article may be found at http://www.cms.gov/Outreach-and-

Education/Medicare-Learning-Network- MLN/MLNMattersArticles/downloads/MM8444.pdf on the CMS website.

If you have any questions, please contact your carrier or Medicare Administrative Contractor at their toll-free number, which may be found at http://www.cms.gov/Outreach-and-Education/Medicare-Learning- Network-MLN/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the CMS website.

News Flash - Generally, Medicare Part B covers one flu vaccination and its administration per flu season for beneficiaries without co-pay or deductible. Now is the perfect time to vaccinate beneficiaries. Health care providers are encouraged to get a flu vaccine to help protect themselves from the flu and to keep from spreading it to their family, co-workers, and patients. Note: The flu vaccine is not a Part D-covered drug. For more information, visit:

- MLN Matters® Article #MM8433, "Influenza Vaccine Payment Allowances - Annual Update for 2013-2014 Season"
- MLN Matters® Article #SE1336, "2013-2014 Influenza (Flu) Resources for Health Care Professionals"
- HealthMap Vaccine Finder - a free, online service where users can search for locations offering flu and other adult vaccines. While some providers may offer flu vaccines, those that don't can help their patients locate flu vaccines within their local community.

The CDC website for Free Resources, including prescription-style tear-pads that allow you to give a customized flu shot reminder to patients at high-risk for complications from the flu.

INCORRECT EXAMPLE

Regional Homecare

Documentation of Face to Face Encounter

Patient Name: Jane Doe ID: 946823410

I certify that this patient is under my care and that I, or a nurse practitioner or physician's assistant working with me, had a face-to-face encounter that meets the physician face-to-face encounter requirements with this patient on (insert date that visit occurred):

Month: 3 Day: 24 Year: 2012

The encounter with the patient was in whole, or in part, for the following medical condition, which is the primary reason for the home health care (List medical condition/s):

Generalized weakness

Additional clinical findings that support home health services (medical necessity) include:

RN: vital signs assessment

PT: home safety assessment

Does not include a brief narrative statement that describes how the patient's clinical condition as seen during that encounter supports the need for skilled services.

I certify, based on my findings, the following services are medically necessary home health services (Check all that apply):

✓ Nursing

✓ Physical Therapy

____ Speech Language pathology

☑ Further, I certify that my clinical findings support that this patient is homebound as defined in CMS Chapter 7 Medicare Benefits Manual 30.0.0 "The condition of the patient is such that there exists a normal inability to leave home and consequently leaving home would require a considerable and taxing effort."

The marked checkbox is insufficient to satisfy the requirement for a brief narrative statement that describes how the patient's clinical condition as seen during that encounter supports the patient's homebound status.

Physician Signature Joe Doe MD

Date of Signature 3/24/2012

Physician Printed Name Joe Doe, MD

Face-to-Face Encounter
John Doe, MD
04/29/2013

Progress Notes

Patient: Smith, Jane
DOB: 04/13/1941
Address: 1714 Main Street, Cedar Avenue, Plano TX 15432

Provider: John Doe, M.D.
Date: 04/28/2013

The certifying physician signed, titled, and dated the face-to-face encounter documentation.

Subjective:

CC:

1. Wound on left heel.

HPI:

Pt is here for evaluation of wound on left heel. Patient reports her daughter noticed the wound on patient's heel when she was washing her feet. Patient states she has difficulty with reaching her feet and her daughter will sometimes clean them for her. She reports she uses a shoe horn to put on her shoes.

ROS:

General:
No weight change, no fever, no weakness, no fatigue.
Cardiology:
No chest pain, no palpitations, no dizziness, no shortness of breath.
Skin:
Wound on left lower heel, no pain.

CORRECT EXAMPLE

Medical History: HTN, hyperlipidemia, hypothryroidism, DJD.

Medications: zolpidem 10 mg tablet 1 tab(s) once a day (at bedtime), Diovan HCl 12.5 mg-320 mg tablet 1 tab(s) once a day, Lipitor 10 mg tablet 1 tab(s) once a day.

Allergies: NKDA

Objective:

Vitals: Temp 96.8, BP 156/86, HR 81, RR 19, Wt 225, Ht 5'4"
Examination: General appearance pleasant. HEENT normal. Heart rate regular rate and rhythm, lungs clear, BS present, pulses 2+ bilaterally radial and pedal. Diminished pinprick sensation on bilateral lower extremities from toes to knees. Left heel wound measures 3 cm by 2 cm and 0.4 cm deep. Wound bed is red, without slough. Minimal amount of yellow drainage noted on removed bandage.

Assessment:

1. Open wound left heel

Plan:

1. **OPEN WOUND** Begin hydrocolloid with silver dressing changes. Minimal weight bear on left leg with a surgical boot on left foot. Begin home health for wound care, family teaching on wound care, and patient education on signs and symptoms of infection. The patient is now homebound due to minimal weight bearing on left foot and restrictions on walking to promote wound healing. Short-term nursing for is needed for wound care, monitor for signs of infection, and education on wound care for family to perform dressing changes.

Follow Up: Return office visit in 2 weeks.

The brief narrative describes how the patient's clinical condition as seen during that encounter supports the patient's homebound status and need for skilled services.

Provider: John Doe, M.D.
Patient: Smith, Jane **DOB**: 04/13/1941 **Date**: 04/28/2013

Electronically signed by John Doe, M.D. on 04/29/2013 at 10:15 AM
Sign off status: Completed

INCORRECT EXAMPLE

All State Home Care Services

Documentation of Face to Face Encounter

Patient Name: John Doe DOB 5/3/1932

I certify that the patient is under my care and that I, or a nurse practitioner or physician's assistant working with me, had a face-to-face encounter that meets the physician face-to-face encounter requirements with this patient on:

12/15/2011

The encounter with the patient was in whole, or in part, for the following medical condition(s), which is related to the primary home health care need (List medical condition[s]):

End stage Renal Disease

I certify that, based in my findings, the following services are medically necessary home health services (Check all that apply):

☐ Nursing ☒ Physical Therapy ☐ Speech language pathology

Medically necessary skilled care/treatments needed (Required only when the physician completing the face to face encounter documentation is different than the physician completing the plan of care):

Skilled Care to assess Home situation

Clinical findings that support the need for the above services:

Renal Disease

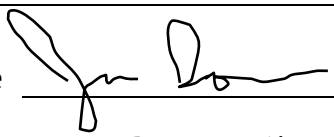
Generalized Weakness

A list of diagnoses is insufficient to satisfy the requirement for a brief narrative statement that describes how the patient's clinical condition as seen during that encounter supports the need for skilled services.

The patient is homebound <u>because</u>: (absences from home require considerable and taxing effort and are for medical reasons or religious services or infrequently or of short duration when for other reasons)

Taxing effort to leave home

Use of general phrases is insufficient to satisfy the requirement for a brief narrative statement that describes how the patient's clinical condition as seen during that encounter supports the homebound status.

Physician Signature  Date of Signature 1/10/2012

Physician Printed Name Jane Doe, MD

CORRECT EXAMPLE

AAA HOSPITAL DISCHARGE SUMMARY
-DEPARTMENT OF SURGERY-

DOE, JANE	00000123	02-13-2012	02-17-2012
Patient Name	Med Rec No.	Admit Date	Discharge Date

Physician: John A. Doe, M.D.
Dictated By: John A. Doe, M.D.

Face to Face Encounter

Date: 2/17/2012

Joe Smith, M.D. 2/20/2012

The discharge summary, which is serving as the face-to-face documentation, is dated and clearly titled as such.
The certifying physician, Dr. Smith, signed the discharge summary, demonstrating that the certifying physician received that information from the practitioner who performed the face-to-face encounter, Dr. Doe, and that the certifying physician is using that discharge summary as his documentation of the face-to-face encounter.

ADMISSION DIAGNOSIS:
Right knee osteoarthritis.

DISCHARGE DIAGNOSIS:
Right knee osteoarthritis.

CONSULTATIONS:
1. Physical Therapy
2. Occupational Therapy

PROCEDURES:
02/14/2012: Total Right knee arthroplasty.

HISTORY OF PRESENT ILLNESS:
Mrs. Doe is a pleasant 60-year old female who has had a longstanding history of right knee arthritis. She has complained of right sided knee pain since January 2011. Since then, her ambulation has been limited by pain and she has pain at night that interrupts sleep. Pain medication, ibuprofen and hydrocodone, have been unsuccessful in relieving her pain for the last 6 months. Workup did show reduction in the right knee joint space. She initially failed conservation treatment and has elected to proceed with surgical treatment.

PAST MEDICAL HISTORY:
Hypertension, Gout.

PAST SURGICAL HISTORY:
Hysterectomy.

The brief narrative describes how the patient's clinical condition as seen during that encounter supports the patient's homebound status and need for skilled services.

DISCHARGE MEDICATIONS:
Colace 100 mg daily, Percocet 5/325 every 4 hours as needed for pain, Lisinopril 10 mg daily, Coumadin 4 mg daily; blood draw for INR ordered for 2/20/2012.

DISCHARGE CONDITION:
Upon discharge Mrs. Doe is stable status post right total knee replacement and has made good progress with her therapies and rehabilitation. Mrs. Doe is to be discharged to home with home health services, physical therapy and nursing visits, ordered. The patient is temporarily homebound secondary to status post total knee replacement and currently walker dependent with painful ambulation. PT is needed to restore the ability to walk without support. Short-term skilled nursing is needed to monitor for signs of decomposition or adverse events from the new Coumadin medical regimen.

PATIENT INSTRUCTION:
The patient is discharged to home in the care of her son. Diet is regular. Activity, weight bear as tolerated right lower extremity. The patient prescribed Coumadin 4 mg a day as the INR was 1.9 on discharge with twice weekly lab checks. Resume home medications. Call the office or return to the emergency room for any concerns including increased redness, swelling, drainage, fever, or any concerns regarding operation or site of incision. The patient is to follow up with Dr. Doe in two weeks.

Transcribed by: A.M 02/17/2012
Electronically signed by: John A. Doe, M.D. 02/17/2013 17:52

CORRECT EXAMPLE

HOME HEALTH CERTIFICATION

Medical Record No.	Start of Care Date:	Certification Period From:	To:
549862	1-28-2012	1-28-2012	3-27-2012

Patient's Name, Address, Phone Number:
Jane Smith
456 Main Street Naples, FL 55555
449-858-6523

Home Health Agency Name, Address, Phone Number:
State Home Care
85 Green Street Naples FL 55555
449-858-2323

Patient Date of Birth:	Sex:	Medication Allergies:
04-20-1934	F	NKDA

ICD-9-CM	Principal Diagnosis	Date
434	Cerebral thrombosis	1-23-2012

ICD-9-CM	Surgical Procedure	Date
N/A		

ICD-9-CM	Other Pertinent Diagnosis	Date
427.31	Atrial fibrillation	1-23-2012
438.84	Ataxia	1-23-2012
440	Atherosclerosis	8-4--2011

Medications: Dose/Frequency/Route:
Coumadin 4 mg PO daily
Lipitor 10 mg PO daily
Coreg 6.25 mg PO twice daily
Celexa 20 mg PO daily

Orders for Discipline and Treatments (Specify Amount/Frequency/Duration):
Skilled nursing x 3/wk x 3 wk; 2/wk x 3 wk for: skilled observation and assessment of the patient's clinical condition including vital signs, for weekly blood draw for INR level and for medication teaching on warfarin.

Physical therapy x 2/wk x 6 wks for strengthening and gait training.

Notify physician of: blood pressure greater than 180/100, temperature greater than 101, and any change in condition.

INR blood draw on 1-31-2102, notify Dr. Doe of results.

DME and Supplies:
Patient uses a walker.

Safety Measures:
Fall precautions.
Bleeding precautions.

Nutritional Requirements
Regular diet.

Functional Limitations
Unsteady gait, uses a walker.

Activity
Up as tolerated, with assistance.

Mental Status
Alert, oriented.

Prognosis
Fair

Goals/Rehabilitation Potential/Discharge Plans

1. Patient will verbalize an understanding of all medications ordered including reason, food and drug interactions, side effects, and schedule for taking.
2. Patient will be independent with wheeled walker for 100 feet on level surfaces by 3-27-2012.
3. Patient will be free from falls.

Encounter documentation is titled.
It includes the date when the physician saw the patient and the narrative describes how the patient's clinical condition supports the patient's homebound status and need for skilled services.
The certifying physician documented the encounter on the certification.

Face-To-Face Encounter

Face-to-Face Encounter Date:

1-27-2012

Face-to-Face Clinical Findings:

Patient was released from the hospital on 1-26-2012 with a diagnosis of CVA. She was started on anticoagulant therapy. She is having difficulty walking and requires assistance to walk. The patient is temporarily homebound due to diminished strength secondary to her recent CVA. She has an unsteady gait and must use assistance to ambulate. Temporary skilled nursing is needed to perform medication teaching on new medication Coumadin. PT is needed to restore strength and her ability to walk.

Physician Certifying Face-to-Face Encounter Signature and Date:

John Doe, MD
1-28-2012

Physician Printed Name:

John Doe, M.D.

The certifying physician signed and dated the face-to-face encounter documentation.

Physician Name and Address:

John Doe, M.D.
32 Peach Street
Naples, FL 55555

Physician Signature and Date:

John Doe, MD
1-28-2012

The physician who established the plan of care certified the necessity for home health services.